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*** Please keep personal information BRIEF this will go in your medical chart.**

Client Information:

Last name: _____ First name: _____
DOB: _____ Age: _____ Gender: _____ Race: _____
Marital Status: _____ Employer/School: _____

*Parent/Guardian Name (if relevant): _____
*Address (same as client): _____
*Phone Number (where a message can be left): (_____)_____
*Emergency Contact (same as parent/guardian): _____Relation: _____
*Address: _____
*Phone Number (where a message can be left): (_____)_____

(***If you have already completed the contact info on the portal - skip filling out the contact info here.**)
*Full Address (Apt#, City, Zip): _____
*Home Phone: (_____) _____ Can a message be left? *At Home:* yes no
*Cell Phone: (_____) _____ Can a message be left? *On Cell:* yes no
*Work Phone: (_____) _____ Can a message be left? *At Work:* yes no
*Number preferred to be contacted at: Home Work Cell
*E-Mail Address: _____ Can a message be left? *E-mail:* yes no

Presenting Problem:

Presenting Problem:
Please briefly indicate the concern(s) that bring you into counseling at this time (mark all that apply and mark P for primary and S for secondary):

___ Depression ____ Anxiety	____ Wanting to harm to self or others	____ High Risk Behaviors	____ Issues with Partner	____ Job Related Issues
____ Panic Attacks ____ Anger	____ Obsessions/ Compulsions	___ Trauma	____ Issues with Family	____ School Related Issues
____ Mood Swings ____ Impulsivity	____ Substance Misuse	____ Difficulty Functioning	____ Issues with Family	____Grief or Loss
___ Difficulty Concentrating	____ Other Addiction	____ Transition/ Difficulty Adjusting	____ General Relational Problems	___ Other: _____ _____

Is/Are this/these problem(s) impacting your: □ Work □ School □ Relationships □ Ability to function in daily life

How long have you been dealing with these concerns? _____

What has helped your progress? _____

What has impaired your progress? _____

What are your goals related to your presenting issues (please make goals: specific, measurable, objective, and/or behaviorally oriented):

1. _____
2. _____
3. _____

How did you learn about my practice? _____

Personal Attributes/Positive Characteristics/Strengths: _____
_____

Coping Tools/Self Care: What do you do to take care of yourself socially, physically, intellectually/mentally, creatively, emotionally, & spiritually? _____
_____

Support System: Who do you turn to for support?: _____

Household:

Please list those that live in your household:

Name	Relation	Age	Live w/FT? yes=✓	Quality of Relationship – i.e. Close, Good, Fair, Poor, Enmeshed, Strained/Conflictual, Non-existent, etc

Family History/Information:

Are your parents: ____ Married/Partnered ____ Separated ____ Divorced (year____) ___Never Married
Your current status: ____ Married/Partnered ___ Re-married ____ Separated ____ Divorced (year_____) ____Single

Other than the people you live with please indicate the following (do NOT include people you live with):

	First Name	Age	De-ceased? yes=✓	Local? yes=✓	Quality of Relationship – i.e. Close, Good, Fair, Poor, Enmeshed, Strained/Conflictual, Non-existent, etc
Mother: □ unknown					
Father: □ unknown					
Step-Mother(s):					
Step-Father(s):					
Siblings:					
Children:					

Custody Arrangements: N/A

If you are a parent (or if you are a minor and you/your parents are divorced), what is the time share/custody arrangement (i.e. do you have them on weekends & holidays, etc):_____

_____

Medical: □ I do not have a regular doctor – but my last medical exam was (month/year) _____

Primary Care Physician: _____

How long with this physician? _____ Date of Last Visit: _____ Phone #: _____

Are they aware you are seeking counseling? ☐yes ☐no Can they be contacted? □Yes □ No (if yes, please sign a release)

Describe Current Medical Problems: □ N/A

Medical Problem	Medications, Supplements, Vitamins, & Herbs with Dose and Frequency Taken Listed	Prescribed By Whom?	Duration of treatment?

Please indicate any current medical issues or symptoms that you have not told your doctor about: □ N/A _____

_____

Please describe relevant past medical history (i.e. hysterectomy, cancer, strokes, heart attacks): □ N/A _____

_____

Please indicate any significant family medical history: □ N/A, □ cancer, □ cardiac disease, □ thyroid or endocrine problems, □ HBP, □ stroke, □ other: _____

Please list any pre-natal, post-natal or developmental challenges you've (the client) has had: _____

_____

** Please indicate any and all medications and other substances to which you are allergic: □ N/A _____

_____

Current Psychiatric Care or Counseling:

Are you currently seeing a psychiatrist □Yes □ No – if yes, please list who: _____
Do they know you are seeing me? □Yes □ No – If No, can they be informed? □Yes □ No (if yes, please sign a release)

Are you currently seeing a another therapist? □Yes □ No – if yes, please list who and what service they are providing for you (i.e. marital
counseling):_____
Do they know you are seeing me? □Yes □ No – If No, can they be informed? □Yes □ No (if yes, please sign a release)

Psychiatric/Psychological/Counseling Treatment History: Check here if this is your first and only experience.

Have you *ever* been hospitalized or in-patient treatment for a mental health or substance abuse issue? Yes No

Year	**Length of Stay**	**Treatment Facility**	**Reason(s)**

Have you *ever* received any other mental health services (i.e. psychiatric care or counseling) of any kind? Yes No

Year	Length of Tx	Name of Provider (& type)	Diagnosis or Reason(s) for Treatment	Medications Given &/or Therapy/Counseling
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N
				Meds? Y/N Therapy? Y/N

Can above listed practitioners or facilities be contacted about the care you received? Yes (release needed) No

Family Psychiatric History: Please indicate any family history of psychological symptoms or disturbances (i.e. depression, anxiety, psychosis, addiction, etc): □ N/A _____
_____

Risks:

Are you currently feeling like you want to hurt or kill yourself? yes no Do you have a plan? yes no
Are you currently feeling like you want to hurt or kill someone else? yes no Do you have a plan? yes no
Do you purposefully, physically hurt yourself? yes no – If yes – how:_____
Are you currently being abused? yes no If yes, by who and how?_____
*Do you have a history of ANY of the previous risks listed above? yes no If yes, please explain: _____
_____

Substance Use History:

Substance	Current Use?	Past Use?	Age of 1st use?	Legal, Vocational or Relational consequences?	Quantity of servings per week on average in last 3 months:	Do you feel it's a current problem for you?	Have you had treatment for it?
Alcohol	Y / N	Y / N		Y / N		Y / N	Y / N
Nicotine	Y / N	Y / N		Y / N		Y / N	Y / N
Pot	Y / N	Y / N		Y / N		Y / N	Y / N
Coke or Crack	Y / N	Y / N		Y / N		Y / N	Y / N
Opiates	Y / N	Y / N		Y / N		Y / N	Y / N
Benzodiazepines	Y / N	Y / N		Y / N		Y / N	Y / N
Uppers/Speed	Y / N	Y / N		Y / N		Y / N	Y / N
Crystal Meth	Y / N	Y / N		Y / N		Y / N	Y / N
Prescription misuse/abuse	Y / N	Y / N		Y / N		Y / N	Y / N
Other:	Y / N	Y / N		Y / N		Y / N	Y / N

CAGE-AID
In the last three months, have you felt you should cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*

In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*
In the last three months, have you felt guilty or bad about how much you drink *or use drugs*? ❍*Yes* ❍ *No*
In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*? ❍*Yes*❍ *No*

Is someone else's substance use affecting you? If yes, explain: _____

Traumatic Events (where you have experience fear of harm or death of you or someone else): □ N/A

Event/What	How long ago?	Is it affecting you now? How?
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐ triggered by noises or other reminders ☐ other:

Loss History: (i.e. death of a loved one or pet, divorce, job, etc) □ N/A

Who/What	Year	Is it affecting you now? How?

Religious/Spiritual Orientation: □ N/A. Please note your orientation: _____

Sexual Orientation: _____

Educational Background: □ Currently a PT student □ Currently a FT student
Highest level of education completed: _____ Where:_____

Military History: □ N/A. Have you, your spouse, or any of your family ever been in the military? Please explain:

_____

How has this impacted you &/or your family? _____

_____

Occupation/Employment/School: □ Employed FT □ Employed PT □ Unemployed □ Disabled □ Retired □ Student
Occupation _____ Name of Employer/School: _____
Duration of employment/disability/unemployment/school: _____ years Performance: □ Good □ AVG □ Poor
How do you feel about your job/school?_____

Financial:
Are you currently experiencing financial difficulties? **Y/N** If yes, explain: _____

_____

Legal Issues:
Are you currently involved in any legal issues? **Y/N** If yes, explain: _____
Do you expect to become involved in any legal issues? **Y/N** If yes, explain: _____
Do you have a history of legal issues? **Y/N** If yes, explain: _____

Current Symptoms in last week to 2 weeks	n/a	mild	moderate	severe
Depressed mood (sad, irritable, blue, down, etc) that last most of the day	□	□	□	□
Loss of interest or pleasure in normally enjoyable things	□	□	□	□
Change in appetite or weight (i.e. significantly changing weight without trying)	□	□	□	□
Failing to keep up with important daily activities (i.e. bills, showers, etc)	□	□	□	□
Sleep disturbance (too much or too little)	□	□	□	□
Decrease/Increase in physical activity (that is uncharacteristic of you normally)	□	□	□	□
Fatigue or loss of energy (i.e. I can't bring myself to do anything)	□	□	□	□
Feeling worthless or excessively guilty	□	□	□	□
Impaired concentration or distractibility	□	□	□	□
Withdrawn	□	□	□	□
Suicidal thinking	□	□	□	□
Thoughts of death	□	□	□	□
Irritable or elevated mood (i.e. frenzied/manic, wound up, aggravated for days)	□	□	□	□
Significant mood or energy swings (each swing last 4 + days – people notice)	□	□	□	□
Inflated self esteem (i.e. I feel I can do in 1 hr what takes someone else 4 hrs to do)	□	□	□	□
Pressure of speech (i.e. I just keep talking and talking)	□	□	□	□
Racing thoughts (i.e. my thoughts spin, race and/or keep me up at night)	□	□	□	□
Excessive spending (i.e. I only have $20 extra a month - I spend $200 instead)	□	□	□	□
Acting out home (i.e. sneaking out, yelling, being disrespectful)	□	□	□	□
Current Symptoms in last week to 2 weeks	n/a	mild	moderate	severe
Acting out school &/or work (i.e. getting in fights, being argumentative, rebellious, etc)	□	□	□	□
Acting out sexually (risky behaviors – i.e. multiple partners, unprotected sex)	□	□	□	□
Acting out stealing (taking things that don't belong to me)	□	□	□	□
Acting out self mutilation (i.e. cutting, burning, scratching myself)	□	□	□	□

Using drugs or alcohol excessively (i.e. taking meds/drugs not prescribed or more than prescribed; drinking until drunk; mixing drugs & alcohol; numbing out)	□	□	□	□
Hyperactivity (i.e. I can't sit still)	□	□	□	□
Impulsivity (i.e. I don't think before I act)	□	□	□	□
Excessive fear or worry (i.e. I worry about a lot of different things)	□	□	□	□
Elevated heart rate when anxious or upset (i.e. my heart races)	□	□	□	□
Sweating when anxious or upset (i.e. when it's not hot sweating uncontrollably)	□	□	□	□
Shaking when anxious or upset (i.e. my body shakes uncontrollably)	□	□	□	□
Shortness of breath when anxious or upset (i.e. feel like can't catch my breath)	□	□	□	□
Choking when anxious or upset	□	□	□	□
Chest pain when anxious or upset	□	□	□	□
Nausea when anxious or upset	□	□	□	□
Lightheaded when anxious or upset	□	□	□	□
Feeling of unreality when anxious or upset	□	□	□	□
Numbness or tingling when anxious or upset	□	□	□	□
Fear of losing control because I'm feeling anxious or upset	□	□	□	□
Chills or hot flashes when anxious or upset	□	□	□	□
Feeling of impending doom (i.e. feeling something terrible is going to happen)	□	□	□	□
Avoidance of social situations due to panic/intense anxiety	□	□	□	□
Recurring unwanted thoughts that cause distress	□	□	□	□
Repetitive behaviors (i.e. counting, checking locks, skin picking, hair pulling, etc)	□	□	□	□
Reliving life threatening events	□	□	□	□
Auditory hallucinations (hearing things not really there)	□	□	□	□
Visual hallucinations (seeing things not really there)	□	□	□	□
Cognitive impairment (forgetting important things or events, the date, people, short or long term memory loss, loosing words often, etc)	□	□	□	□

Other symptoms you are experiencing that are not listed: _____

_____

These symptoms are: □ distressing to me and/or my loved ones □ not distressing
These symptoms are affecting my: □ work □ school □ relationships □ability to function normally in daily life